Virginia Workers' Compensation Commission
Request for Mediation

VWC/JCN File Number: _____

Date of Injury: _____

Person Requesting Mediation:

☐ **Claimant** ☐ **Claimant Attorney**

☐ **Claims Administrator** ☐ **Claims Administrator Attorney**

☐ **Other:** _____

Name: _____

Phone #: (_____) _____

Fax #: (_____) _____

Address: (Number, Street, Apt., City, State and Zip)

_____

_____

Describe the issue that you believe should be the subject of the mediation:

_____

_____

_____

I consent to mediation of this matter by an employee of the Virginia Workers' Compensation Commission. I understand if one of the other parties objects to this request the matter will not be referred for mediation.

Signature: _____ **Date:** _____

Mail or Fax this form to:
Mediation Scheduler
Virginia Workers' Compensation Commission
1000 DMV Drive
Richmond, Virginia 23220
FAX: 804-367-9740